

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

27618

1. PLACE OF DEATH

County St. Louis, Mo.

Township Carondelet

City Jefferson Barracks, Mo.

Registration District No. 1123

Primary Registration District No. 6248

Veterans Administration Facility.

File No. _____

Registered No. 263

St. _____ Ward) _____

2. FULL NAME Alander DYSON

(a) Residence, No. 4202 Aldine Pl., St. Louis, Mo. Ward. _____

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred - yrs. - mos. - ds. How long in U.S., if of foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE Colored 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married (Separated)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Jessie Dyson (Separated)

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 23, 1878

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
55 1 15

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Mechanic

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Business for Himself

10. Date deceased last worked at this occupation (month and year) Abt. 1 yr. ago 11. Total time (years) spent in this occupation Abt. 1 yr.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Missouri.

13. NAME Israel Dyson

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Boone Co., Missouri.

15. MAIDEN NAME Elizabeth Gamble

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Thytire, Mississippi

17. INFORMANT (ADDRESS) C. H. SMITH, M.D. Clinical Dir. Veterans Adm. Fac. Jeff. Brks., Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenwood Cem. DATE Aug. 12, 1933

19. UNDERTAKER (ADDRESS) L. Wade Longbray & Mc Cain 4209 W. Eastern

20. FILED Aug 14 1933 L. C. Obrockm. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) August 8, 1933

I HEREBY CERTIFY, That I attended deceased from August 5, 1933, to August 8, 1933

I last saw him alive on August 8, 1933 Death is said

to have occurred on the date stated above, at 4:25 p.m.

The principal cause of death and related causes of importance were as follows:

Tuberculosis, pulm. chr. far advanced, active, all lobes.

Date of onset

Unk.

Other contributory causes of importance: 23A

Name of operation Clinical, physical, x-ray & laboratory Date of findings What test confirmed diagnosis? No Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased?

If so, specify _____

(Signed) W. C. GIBSON, M.D. Manager, Vet. Adm. Facility, Jeff. Brks., Mo.

(Address) _____

